DENTAL PATIENT MEDICAL HISTORY

Patient Name: ______________________________ DOB: ______________________ Chart #:______________________

Reason for Dental Visit? ______________________________ When was you last dental visit? ____________________________

Do You Have a Toothache Now? (Please Circle) Yes No If Yes, on a scale of 1-10, with 10 being the most painful, what is your pain level? _____

If you are unsure of how to answer any of the questions below, please ask dental staff for help! Do you have or have you had any of the following? (Please check)

	Yes	No		Yes	No
*Organ Transplant -- *Date:*			Epilepsy, Seizures, or Nervous System Disease		
*Joint Replacement (hip, knee, ankle, shoulder) -- *Date:*			Stroke		
			Allergy to latex, iodine, or red dye (circle all that apply)		
*Artificial Heart Valve -- *Date:*			Allergy to: metal or local anesthetics *(circle)*		
*Congenital Heart Disease, Defect, or Heart Murmur:			Cancer/tumors -- *Dates:* *Type:*		
*Bacterial Endocarditis (SBE)			Chemotherapy or Radiation -- *Dates:*		
* Kidney Problems or Dialysis *(circle)*			Tuberculosis -- *currently* or *in past* *(circle)*		
*Spleen removed			Asthma, or other Lung Disease		
Steroid Use (e.g. prednisone) -- *Dates:*			Ulcers		
HIV or AIDS or do you believe you have been exposed?			Arthritis		
Lupus (SLE)			Osteoporosis		
Rheumatoid Arthritis			Thyroid Problems --- *High* or *Low* *(circle)*		
Diabetes: *Type I* *Type II* *(circle)*			Mental Health Condition:		
Other Immunosuppressive Condition:			Physical or Mental Disability that requires special consideration:		
Hepatitis -- *treated in past* or *currently active* *Type:*					
Other Liver Disease			Chemical Dependency (alcohol /other drugs)		
Pacemaker / Defibrillator or other Artificial Device / Implant -- *Date*:			Do you smoke or chew tobacco?		
			If yes, are you interested in quitting?		
Congestive Heart Failure			Any other disease or condition?		
Heart Disease or Heart Attack -- *Dates:*					
Chest Pain / Angina			**WOMEN ONLY:**		
High Blood Pressure			Are you pregnant?		
Have you or are you taking blood-thinners?			Are you nursing?		
Anemia or Abnormal Bleeding or Bruising			Are you taking birth control?		

Depression Screening Questions: Over the past 2 weeks have you been bothered by:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**

List any medications that you are allergic to and what type of reaction: ____

List medications you currently take (including over-the-counter drugs): ____

Date of last medical appointment____________________ Primary Care Provider Name ______________________________

Have you ever been hospitalized? _____________ When and What for? ______________________________________

Do you have any disease, condition, or problem not listed? No ☐ Yes ☐ (If yes, specify) ______________________________
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<u>IMPORTANT</u>! The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, fillings, local anesthesia, blood pressure, and glucose by signing below on behalf of myself or the below named minor in my guardianship.

______________________________ ____________________
Signature (Patient or guardian if patient is a minor) *Date*

______________________________ ____________________
Signature (Dentist/Hygienist) *Date*